Incontinence Supplies (Age 21 and over)

Definition: Diapers, underpads, wipes, liners, and disposable gloves provided to participants who are at least **twenty-one (21) years old** and who are incontinent of bowel and/or bladder according to the established medical criteria.

Providers: Incontinence supplies are to be provided by licensed **vendors enrolled with SCDHHS as Incontinence Supply providers.**

Criteria: The following criteria must be met for individuals to receive incontinence supplies:

1. The waiver participant must be age 21 or above.
2. The waiver participant's inability to control bowel or bladder function must be confirmed by a Physician on the **Physician Certification of Incontinence (DHHS Form 168IS**).
3. The Service Coordinator must conduct an assessment to determine the frequency and amount of supplies authorized

Covered Supplies: Medically Necessary Incontinence supplies are available through the Medicaid State Plan which must be accessed prior to the Intellectual Disability/Related Disabilities (ID/RD) Waiver.

Medicaid State Plan offers the following based on medical necessity:
- One (1) case of diapers or briefs [1 case = 96 diapers or 80 briefs]
- One (1) case of incontinence pads/liners [1 case = 130 pads]
- One (1) case of underpads
- One (1) box of wipes
- One (1) box of gloves

In addition to incontinence supplies offered by Medicaid State Plan, the ID/RD waiver may offer the following based on documented need in the individual's record.

- One (1) box of disposable gloves monthly
- Up to two (2) cases of diapers/briefs monthly [1 case = 96 diapers or 80 briefs]
- Up to two (2) cases of underpads monthly
- Up to eight (8) boxes of wipes monthly
- Up to two (2) boxes of incontinence pads (liners) monthly [1 case = 130 pads]

Please note: it is possible that incontinence supplies offered by the Medicaid State Plan and the ID/RD waiver may not meet the requests presented by all waiver participants.

Arranging for the Service: Once the individual's need has been identified and documented in the plan and the participant's record, you must determine if the individual is eligible for incontinence supplies by having a physician complete the **Physician Certification of Incontinence (DHHS Form 168IS).** This form must be completed annually. Upon completion of the physician certification, you must conduct a telephone assessment to determine the frequency of incontinence and the amount of supplies to be authorized. The frequency definitions are as follows:

Occasionally Incontinent =
- Bladder—Not daily. Approximately 2 or less times a week
- Bowel—Approximately once a week

Frequently Incontinent =

- Bladder—Approximately between 3 to 6 times a week, but has some control OR if the client is being toileted (w/extensive assistance) on a regular schedule.
- Bowel—Approximately between 2 to 3 times a week.

Totally Incontinent =

- No control of bladder or bowel

NOTE: If the individual has an ostomy or catheter for urinary control <u>and</u> an ostomy for bowel control, <u>only</u> underpads may be authorized.

NOTE: If the individual has an appliance for bowel <u>or</u> bladder control, diapers may be authorized based on the frequency of incontinence.

In order to receive diapers funded through the waiver in addition to the State Plan allowable amounts the individual should be assessed as being more than "Frequently Incontinent". When conducting the assessment the Service Coordinator should consider the number of diapers used on average/per day to calculate the number of cases of diapers and/or other supplies needed per month. <u>This should be thoroughly recorded in service notes to justify the need and communicated via the budget comments</u>.

Once a frequency and amount has been determined and the budget has been approved, the individual must make a choice of provider and you must send an **Authorization for Incontinence Supplies (Form IDRD IS-1)** to the provider. A copy of the authorization must remain in the individual's file.

<u>Note:</u> An authorization for wipes is based on the presence of an incontinence need only; therefore, <u>an individual must also be receiving diapers and/or underpads in order to receive wipes. Wipes cannot be authorized for cosmetic or other general hygiene purposes. They can only be authorized for the participant's incontinence care.</u>

<u>Monitoring the Services:</u> The Service Coordinator must monitor the service for effectiveness, usefulness and participant satisfaction. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following guidelines should be followed when monitoring Incontinence Supplies

- Services should be monitored at least once during the first month of service.
- Services should be monitored at least once during the second month of service.
- Services must be monitored at least quarterly.
- Monitoring must start over any time there is a change of provider.
- Monitoring of this service may be conducted by contact with the participant/family or with the service provider.

<u>Questions to consider</u>

- → Has the individual's health status changed since your last monitorship? If so, do all authorized supplies continue to be needed at the current rate?
- → Are the amounts appropriate or do they need to be changed?
- → Has the participant improved in his/her ability to toilet? If so, can the amount of supplies be decreased?
- → Are there any new needs?
- → Does the individual receive his/her monthly supplies in a timely manner?
- → When was the last time the supplies were received?
- → Is he/she satisfied with the provider of the service?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the individual or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal/reconsideration, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). See **Chapter 9** for specific details and procedures regarding written notification and the appeal process.

SCDDSN RECONSIDERATION AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disability/Related Disabilities (ID/RD) Waiver, the Pervasive Developmental Disorder (PDD), the Community Supports Waiver (CSW) and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision must be sent in writing to:

State Director
SCDDSN
P. O. Box 4706
Columbia, SC 29240

The SCDDSN reconsideration process must be completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the participant, the representative or the person assisting the participant in filing the request. If necessary, staff will assist the participant in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the participant/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the participant/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the participant/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the participant/representative fully completes the above reconsideration process and is dissatisfied with the results, the participant/representative has the right to appeal to the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The participant/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The participant/representative must attach a copy of the written reconsideration notification received from the SCDDSN regarding the specific matter that is the subject of the appeal. In the appeal request, the participant/representative must clearly state with specificity, which issue(s) the participant/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The participant/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
INTELLECTUAL DISABILITY/RELATED DISABILITIES (ID/RD) WAIVER
AUTHORIZATION FOR INCONTINENCE SUPPLIES FOR INDIVIDUALS 21 AND OVER

BILL TO S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES (include Prior Authorization # below)

TO: _____
Provider Name

Participant's Name: _____ **Date of Birth:** _____ **(Must be over 21 years old)**

Address: _____

_____

Phone Number: _____ **Medicaid #:** _____

Prior Authorization # _____

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing the ID/RD Waiver. Our information indicates this person has:

☐ Medicaid only ☐ 3rd Party liability (private insurance) ☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for these services.

*****ATTENTION PROVIDERS: All WAIVER procedure codes for incontinence supplies must be billed using the modifier "OSC" (using a "zero", not the letter "O"). State Plan Procedure Codes for incontinence supplies below DO NOT require a modifier. The quantity must be indicated for each procedure code in order for claims to pay correctly. State Plan and Waiver procedure codes must be billed on separate lies of the claim form.***

Quantity of Items:

☐ **Diapers*:** _____ diapers billed through State Plan (Maximum 96 diapers), _____ diapers billed through Waiver (Maximum 192 diapers)

Size: ☐ Adult SM (T4521) ☐ Adult MD (T4522) ☐ Adult LG (T4523) ☐ Adult XL (T4524) ☐ Bariatric (T4543)

Diaper Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Briefs*:** _____ briefs billed through State Plan (Maximum 80 briefs), _____ briefs billed through Waiver (Maximum 160 briefs)

Size: ☐ Adult SM (T4525) ☐ Adult MD (T4526) ☐ Adult LG (T4527) ☐ Adult XL (T4528)

Brief Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Incontinence Pads (liners) (T4535):** _____ liners billed through State Plan (Maximum 130 pads), _____ liners billed through Waiver (Maximum 260 pads)

Pad Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Under Pads (A4554):** _____ cases billed through State Plan (Maximum 1 case), _____ cases billed through Waiver (Maximum 2 cases)

Under Pad Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Wipes (T5999):** _____ boxes billed through State Plan (Maximum 1 box), _____ boxes billed through Waiver (Maximum 8 boxes)

Wipe Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Gloves (A4927):** _____ box billed through State Plan (Maximum 1 case), _____ box billed through Waiver (Maximum 1 case)

Glove Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

**Briefs and Diapers combined cannot equal more than a total of 3 cases per month (96 diapers per case, 80 briefs per case)*

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____

_____

Phone # _____

_____ _____

Signature of Person Authorizing Services Date